The Delaware Speech & Hearing Center
740-369-3650

_____
Today's Date

Client Registration, Consent Release, and Financial Policy Form (R06/2010)

Patient Name (First)_____MI___(Last)_____

SS#:_____ DOB: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ☐ Employed ☐ Student ☐ Other

Responsible Party (if different from primary insured)

Name (First)_____MI___(Last)_____

Address: _____

City _____ Zip _____ Phone: _____

SS#:_____ DOB: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ____ Widow ____ Other

Primary Insurance Information

Insurance: _____

Insured's Name (First)_____MI___(Last)_____

Address: _____

City _____ Zip _____ Phone: _____

SS#:_____ DOB: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other

ID # _____ Group #: _____

Employer: _____ Phone _____

Secondary Insurance Information

Insurance: _____

Insured's Name (First)_____MI___(Last)_____

Address: _____

City _____ Zip _____ Phone: _____

SS#:_____ DOB: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other

ID # _____ Group #: _____

Employer: _____ Phone _____

Referred By:

Physician Information

Physician Name: _____

Practice Name: _____Phone:_____

Address:_____Fax:_____

City _____ State _____ Zip_____

PLEASE COMPLETE OTHER SIDE

Consent for Treatment

I hereby give my permission to the staff of the Delaware Speech and Hearing Center to carry out all necessary audiologic/speech language pathology diagnostic and/or treatment activities which meet the needs of the above-mentioned client. I understand that the services provided to me or my child will be conducted by qualified audiologists/speech language pathologists who hold the Certificate of Clinical Competence from the American Speech and Hearing Association or who have applied and are in their CFY year. I also give my permission to the Delaware Speech and Hearing center to release any information acquired in the course of examining _____to:

1) Physician as listed (date faxed) _____ (date mailed) _____ ☐ MC attached
2) Other: _____
3) Other: _____

Financial Policy

WE ACCEPT CASH, CHECK, MASTERCARD, VISA

I agree to pay for the services rendered according to the fee schedule established by the Center's Board of Directors. I have also read and agree to the Center's Financial Policy as stated:

We are a non-profit organization, therefore we request a full payment at the time of your visit unless you have Medicaid, Medicare, or private insurance. We will collect your copayment or coinsurance at the time of your visit. We will submit your claim, however, your insurance policy is a contract between you and your company. Please be aware, some and perhaps all the services provided may be "non-covered" services, and not considered reasonable and necessary under the Medicare Program and/or other medical insurance in which case you will be responsible for the balance.

Speech therapy sessions are paid in full at the time of service. Upon receipt from your insurance carrier, a reimbursement will be made. Reimbursement is made based upon actual payment received and not subject to UCR guidelines.

Personal Health Information Amendment: If there is any information in the evaluation report(s) that is incorrect, or not properly stated, you have the right to request an amendment to your PHI. If you would like to request an amendment, please contact the Center and a Request for Correction/Amendment of Health Information will be mailed to you. I understand this is my responsibility if so desired.

Notifications of appointments or Center events will be mailed post card style unless otherwise directed not to.

FOR OUR AUDIOLOGY MEDICARE CLIENTS:

ADVANCE NOTICE (PATIENT DISCLOSURE) FORM FOR MEDICAL NECESSITY

"Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law.

If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

We believe that in your case, Medicare is likely to deny payment for our office visit (99211; $30.00) fee for the following reason: Medicare does not pay for the OV by this type of provider. **BENEFICIARY AGREEMENT:** I have been notified by my audiologist that he/she believes that, in my case, Medicare is likely to deny payment for the service identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

I acknowledge and agree to the above financial policy. I also give consent to release any and all information as pertains to my insurance claim to my insurance carrier. I also give consent to have payment sent directly to The Delaware Speech and Hearing Center. I acknowledge and understand the Personal Health Information Amendment and Advance Notice. I understand and have been provided with a *Notice of Information Practices* that provides a complete description of information uses and disclosures.

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Signature Relationship Dated